

**North Carolina Department of Health and Human Services  
Division of Public Health • Epidemiology Section  
Communicable Disease Branch**



**ATTENTION HEALTH CARE PROVIDERS:**

Please report relevant clinical findings about this disease event to the local health department.

**MENINGITIS, PNEUMOCOCCAL**  
Confidential Communicable Disease Report—Part 2  
NC DISEASE CODE: 25

**REMINDER to Local Health Department staff: If sending this form to the Health Care Provider, remember to attach a cover letter from your agency indicating the part(s) of the form the provider should complete.**

Patient's Last Name	First	Middle	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

**NC EDSS LAB RESULTS** Verify if lab results for this event are in NC EDSS. If not present, enter results.

LABORATORY TESTING: Isolation of *S. pneumoniae* from cerebrospinal fluid (CSF) or Isolation of *S. pneumoniae* from another normally sterile site (e.g. blood, or, less commonly, joint, pleural or pericardial fluid) with clinical evidence of meningitis.

Specimen Date	Specimen #	Specimen Source	Type of Test	Test Result(s)	Description (comments)	Result Date	Lab Name— City/State
/ /						/ /	
/ /						/ /	
/ /						/ /	

**NC EDSS PART 2 WIZARD COMMUNICABLE DISEASE**

Is/was patient symptomatic for this disease?  Y  N  U  
 If yes, symptom onset date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 CHECK ALL THAT APPLY:

**Fever**  Y  N  U  
**Altered mental status**  Y  N  U  
**Headache**  Y  N  U  
**Stiff neck**  Y  N  U  
**Eyes sensitive to light (photophobia)**  Y  N  U  
**Elevated CSF protein?**  Y  N  U  
**Elevated CSF cell count?**  Y  N  U  
**Seizures / convulsions**  Y  N  U

**Other symptoms, signs, clinical findings, or complications consistent with this illness?**  Y  N  U  
 Specify: \_\_\_\_\_  
**Any immunosuppressive conditions?**  Y  N  U  
 Specify: \_\_\_\_\_

**Does the patient have an autoimmune disease?** (e.g. systemic lupus erythematosus, rheumatoid arthritis)  Y  N  U  
 Specify:  
 Systemic lupus erythematosus  
 Other, specify: \_\_\_\_\_

**A hematological disease?**  Y  N  U  
 Specify:  
 Sickle Cell  Y  N  U  
 Other, Specify: \_\_\_\_\_

**Malignancy?**  Y  N  U  
 Specify:  
 Lymphoma/Hodgkin's Disease  Y  N  U  
 Multiple myeloma  Y  N  U  
 Leukemia  Y  N  U  
 Other, Specify: \_\_\_\_\_

**Cardiovascular/heart disease, including congenital heart disease?**  Y  N  U  
 Specify:  
 Heart failure /CHF  Y  N  U  
 Congenital heart disease  Y  N  U  
 Other, Specify: \_\_\_\_\_

**Liver disease?**  Y  N  U  
 Specify:  
 Chronic liver disease or cirrhosis  Y  N  U  
 Liver Failure  Y  N  U  
 Other, Specify: \_\_\_\_\_

**Kidney disease?**  Y  N  U  
 Specify:  
 Nephrotic syndrome  Y  N  U  
 Chronic renal failure  Y  N  U  
 Is the patient on dialysis?  Y  N  U  
 Other, Specify: \_\_\_\_\_

**A chronic lung disease?**  Y  N  U  
 Specify:  
 Emphysema/COPD  Y  N  U  
 Asthma/reactive airway disease  Y  N  U  
 Cystic fibrosis  Y  N  U  
 Other, Specify: \_\_\_\_\_

**A CSF leak or cochlear implant?**  Y  N  U  
**Splenectomy or is the patient asplenic?**  Y  N  U  
**Any other underlying illness?**  Y  N  U  
 Specify: \_\_\_\_\_

**Was the patient receiving ANY immunosuppressive treatments or medication?**  Y  N  U  
 Specify: \_\_\_\_\_  
 For what medical condition: \_\_\_\_\_

**Was patient hospitalized for this illness >24 hours?**  Y  N  U  
 Hospital name: \_\_\_\_\_  
 City, State: \_\_\_\_\_  
 Hospital contact name: \_\_\_\_\_  
 Telephone: (\_\_\_\_) \_\_\_\_ - \_\_\_\_\_  
 Admit date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Discharge date (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
**ICU admission?**  Y  N  U  
**Discharge/Final diagnosis:** \_\_\_\_\_

**Does the patient smoke?**  Y  N  U  
**Has the patient ever received pneumococcal vaccine?**  Y  N  U  
 If yes, type:  
 **Pneumococcal polysaccharide vaccine (PPV-23)**  
 Number of doses: \_\_\_\_\_  
 Date of last vaccination (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Vaccination date unknown  
 **Pneumococcal conjugate vaccine (PCV-7)**  
 Number of doses: \_\_\_\_\_  
 Date of last vaccination (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Vaccination date unknown  
 **Vaccine type unknown**  
 Number of doses: \_\_\_\_\_  
 Date of last vaccination (mm/dd/yyyy): \_\_\_/\_\_\_/\_\_\_  
 Vaccination date unknown

Patient's First Name	Middle	Last	Suffix	Maiden/Other	Alias	Birthdate (mm/dd/yyyy) / /
						SSN / /

**CLINICAL OUTCOMES**

Survived? .....  Y  N  U

Died? .....  Y  N  U

Died from this illness? .....  Y  N  U

Date of death (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

**BEHAVIORAL RISK & CONGREGATE LIVING**

During the 7 days prior to onset of symptoms did the patient live in any congregate living facilities (correctional facility, barracks, shelter, commune, boarding school, camp, dormitory/sorority/fraternity)? .....  Y  N  U

Name of facility: \_\_\_\_\_

Dates of contact: \_\_\_\_\_

In what setting was the patient most likely exposed?

<input type="checkbox"/> Restaurant	<input type="checkbox"/> Place of Worship
<input type="checkbox"/> Home	<input type="checkbox"/> Outdoors, including woods or wilderness
<input type="checkbox"/> Work	<input type="checkbox"/> Athletics
<input type="checkbox"/> Child Care	<input type="checkbox"/> Farm
<input type="checkbox"/> School	<input type="checkbox"/> Pool or spa
<input type="checkbox"/> University/College	<input type="checkbox"/> Pond, lake, river or other body of water
<input type="checkbox"/> Camp	<input type="checkbox"/> Hotel / motel
<input type="checkbox"/> Doctor's office/ Outpatient clinic	<input type="checkbox"/> Social gathering, other than listed above
<input type="checkbox"/> Hospital In-patient	<input type="checkbox"/> Travel conveyance (airplane, ship, etc.)
<input type="checkbox"/> Hospital Emergency Department	<input type="checkbox"/> International
<input type="checkbox"/> Laboratory	<input type="checkbox"/> Community
<input type="checkbox"/> Long-term care facility /Rest Home	<input type="checkbox"/> Other (specify) _____
<input type="checkbox"/> Military	<input type="checkbox"/> Unknown
<input type="checkbox"/> Prison/Jail/Detention Center	

**CASE INTERVIEWS/INVESTIGATIONS**

Was the patient interviewed? .....  Y  N  U

Date of interview (mm/dd/yyyy): \_\_\_\_/\_\_\_\_/\_\_\_\_

Were interviews conducted with others? .....  Y  N  U

Who was interviewed? \_\_\_\_\_

Were health care providers consulted? .....  Y  N  U

Who was consulted? \_\_\_\_\_

Medical records reviewed (including telephone review with provider/office staff)? .....  Y  N  U

Specify reason if medical records were not reviewed: \_\_\_\_\_

Notes on medical record verification: \_\_\_\_\_

**TRAVEL/IMMIGRATION**

The patient is:

Resident of NC

Resident of another state or US territory

None of the above

**CHILD CARE/SCHOOL/COLLEGE**

Patient in child care? .....  Y  N  U

Patient a child care worker or volunteer in child care? .....  Y  N  U

Patient a parent or primary caregiver of a child in child care? .....  Y  N  U

Is patient a student? .....  Y  N  U

Type of school: \_\_\_\_\_

Is patient a school WORKER / VOLUNTEER in NC school setting? .....  Y  N  U

Give details: \_\_\_\_\_

**OTHER EXPOSURE INFORMATION**

Does the patient know anyone else with similar symptoms? .....  Y  N  U

Specify \_\_\_\_\_

**GEOGRAPHICAL SITE OF EXPOSURE**

In what geographic location was the patient MOST LIKELY exposed?

Specify location:

In NC

City \_\_\_\_\_

County \_\_\_\_\_

Outside NC, but within US

City \_\_\_\_\_

State \_\_\_\_\_

County \_\_\_\_\_

Outside US

City \_\_\_\_\_

Country \_\_\_\_\_

Unknown

Is the patient part of an outbreak of this disease? .....  Y  N

Notes: \_\_\_\_\_

# Meningitis, Pneumococcal

## 2007 Case Definition (North Carolina)

### Clinical description

*Streptococcus pneumoniae* infection can cause a wide range of clinical syndromes. In North Carolina, only cases of pneumococcal meningitis are reportable. Clinical evidence of meningitis can include headache, stiff neck, altered mental status, white blood cells in spinal fluid, etc.

### Laboratory criteria for diagnosis

Isolation of *S. pneumoniae* from cerebrospinal fluid (CSF) by culture or PCR, **OR**

Positive antigen test (e.g., latex agglutination or counter immunoelectrophoresis) for *S. pneumoniae* from CSF

### Case classification

*Confirmed:* Isolation of *S. pneumoniae* from cerebrospinal fluid (CSF)

*Probable:* Clinically compatible case of meningitis with a laboratory-confirmed culture of *S. pneumoniae* from another normally sterile site other than CSF, **OR**

Clinically compatible case with other supportive laboratory findings (LA, CIE) with clinical evidence of meningitis and no other specific etiology identified.

Note: The NC case definition for pneumococcal meningitis is not the same as the CDC case definition for invasive streptococcal pneumoniae disease.